Woodrow Wilson Rehabilitation Center
Application for Statewide Offsite Services

Service Requested: _____ Dates of Service: _____

Requested by: _____ Date of Application: _____
(Counselor/Counselor #/Referral Source)

Instructor/Therapist Name: _____
(Who is providing this service?)

Client Information

Client's Name:
_____|_____|_____
(Last) (First) (Middle)

Client's Address:
_____|_____
(Street) (City/State/ZIP)

Client's Phone #: _____

_____|_____|_____|_____
(Social Security Number) (Birth Date) (Male/Female) (Marital Status)

_____|_____|_____
Accident Type (i.e. MVA) Date of Injury Last Grade Completed

Referral Source Information

Referral Source: _____ DRS Status: _____ DRS Case #: _____

Disability and/or RSA Code(s): _____

Vocational Objective:
_____

Payer Information

_____|_____
(Name of Insurance/Payer) (Policyholder Name and Number)

_____|_____
(Address of Insurance Co./Payer) (Insurance/Payer Phone Number)

If DRS, is this full sponsorship? YES NO If no, indicate % of client responsibility: _____